Patient Education in Primary Care

Volume 7 Issue 2 October 2003

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Welcome to our resource for patient education and primary care![1]

WHAT IS IT?

This newsletter provides a mechanism to help meet the challenges of incorporating effective patient education into primary care.

WHO IS IT FOR?

VA Primary Care Teams, Patient Health Education Coordinators or Patient Health Education Committee chairs, VISN and VAMC decision makers.

My HealtheVet Website for Veterans

The My Health*e*Vet project reached a milestone when Phase 1 of the website effort became operational on Veterans Day 2003. My Health*e*Vet is a web-based application that creates a new, online environment where veterans, their families, and clinicians may come together to optimize veterans' health care. Nationwide implementation will occur through three phases, each with increasingly complex functionality and security.

Features of My Health*e*Vet

- The system offers universally available electronic access to veteran services and information.
- Participation in the system is voluntary.
- Each participating veteran will have access to and control of his/her online environment; veterans can select functions to suit personal needs and interests.
- A Health Education Library is available to look up information on medical conditions, medications, health news, and preventive health.
- Veterans will be able to request and store copies of key portions of their VA health records in a secure, unique and personal repository (*e*VAult).

1. This publication may be duplicated.

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- Veterans will be able to enter measurements in five self-entered metrics (*e*logs) (blood pressure, blood sugar, cholesterol, weight, heart rate), and chart their progress on these readings.
- All personal health information is guaranteed to be private and secure.
- Each participating veteran will be able to delegate access to all or some of his/her health information to others, such as family or veteran advocates, and VA and non-VA health care providers.

When fully implemented, My Health*e*Vet will provide a unique combination of characteristics not available in other products. The system will:

- enable each veteran to become a full and capable partner in his/her own health management
- emphasize the clinician/patient relationship, enhancing communication and sharing health decision-making
- encourage self-service health risk assessments to maintain and improve wellness
- permit family, relatives, and non-VA physicians to assist and advise in health management and decisions based on permission and authorization from the veteran
- provide veteran-specific educational materials on conditions that affect VA patients
- provide each veteran with a secure, unique and personal repository (*e*VAult) for a copy of key portions of his/her VistA electronic health record, as well as self-entered measurements and notes
- meet Health Insurance Portability and Accountability Act (HIPAA) requirements, such as consumer control, privacy compliance, and audit tracking.

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Benefits for Veterans

Increasingly, veterans are requesting access to their health information and seeking to play a more active role in their health care. With My Health*e*Vet, veterans will be able to:

- use the system's tools to become partners with their caregivers in their health care
- explore a variety of options to improve their health
- control the health information in their *e*VAults
- gain a better understanding of their health status.

More specifically, My Health*e*Vet has these benefits for veterans:

- Educated, empowered patients can take a more active role in self-management and in shared health care decision making.
- Patients who take a more active role in their health care have been found to have improved clinical outcomes and treatment adherence, as well as increased satisfaction with their care.
- Veterans will be able to allow VA clinicians to track patient-entered metrics such as blood pressure, blood glucose, weight, and pulse. This will give the clinician a more detailed picture of the patient's health without having to wait to see the patient in person, so problems can be averted more quickly.
- Veterans will be able to let VA clinicians see medical information from other health care providers that the veteran has added to the self-entered section. This will provide a more complete picture of the patient's total care.
- Veterans will be able to allow non-VA providers to see their VA medical care history.
- Veterans can ask veteran advocates, such as veteran service officers (VSOs), to act as delegates (with permission) and review their health record data. This will enable advocates to guide veterans through the VA claims process better and ensure that veterans are getting the care they need.

Benefits for VA Clinicians

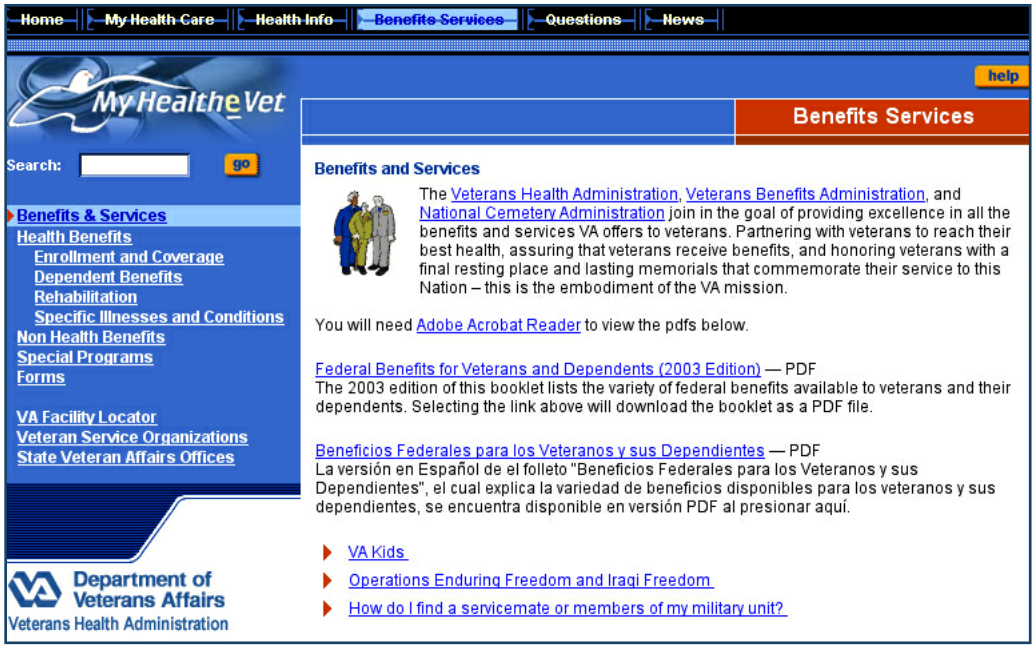
My Health*e*Vet offers a number of advantages for VA clinicians. Clinicians will be able to:

- communicate and collaborate with veterans much more easily.
- use their electronic progress notes as a tool for patient education, since veterans will be able to view the notes from home and refresh their memories of the clinician's instructions.
- see a more complete picture of the patient's health condition and health care, including non-VA care.

Benefits for VHA

My Health*e*Vet offers substantial benefits to VHA program offices:

- It provides a single touch point to reach the entire veteran population so that health bulletins, seasonal reminders and daily health tips can be broadcast.



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- It is an interactive tool so that veterans can respond to messages or submit requests to receive additional information.
- The new online environment will map closely to existing clinical business practices, while extending the way care is delivered and managed.
- As veterans build up their lifelong health records, they will be able to choose to share all or part of the information in their account with all their health care providers, inside and outside the VA. This has the potential to dramatically improve the quality of care available to our nation's veterans.

Phase 1

In the first phase of the project, the website offers veterans a single source to find out about VA services, benefits, and special programs. My Health*e*Vet gathers and showcases information developed by VA program offices. It allows VA to respond to questions from veterans.

In this phase, My Health*e*Vet also provides clinically sound health information on a variety of topics relevant to veterans through HealthGate, which offers a variety of tools including:

- prescription checker
- anatomy explorer
- condition explorer
- health calculators
- self-assessment tools.

VA clinicians at facilities that have downloaded the program can also link to HealthGate from the toolbar on the computerized medical record system. In Phase 1, security requirements are minimal; users self-register through the website.

Phase 2

Additional functions will be incorporated into the website in Phase 2 which is scheduled to become operational this summer. At that time, veterans will be able to enter and store their own personal health information in a secure *e*VAult. Items can include personal demographics, contact information on all providers and insurers, personal history of medical events and tests, allergies, and current medications. Veterans also will be able to:

- review and refill VA prescriptions
- view future clinic appointments made at VA health care facilities
- view co-pay balances
- enter and track their own data in order to monitor blood pressure, blood sugar, cholesterol, weight and heart rate
- create self-defined *e*logs as desired.

In Phase 2, the VHA master patient index will be used to verify a veteran's identity.

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Phase 3

Phase 3, scheduled for release in 2005, will allow veterans to establish personal electronic health records. Veterans will be able to view and maintain a copy of key portions of their secure personal health record from VA's health information system, Health*e*Vet/VistA. Extracts from their medical records can be sent to their My Health*e*Vet accounts including:

- demographics, admissions and appointments
- vital signs and allergies
- prescriptions
- progress notes
- discharge summaries
- basic problem list information
- lab reports (chemistry, microbiology, microscopy, cytology and pathology)
- ECG and radiology reports.

In Phase 3, security requirements will be most stringent; a veteran will need to be verified in person at a VA health care facility in order to be given an account for his/her own electronic health record.

Implementation of the Project

Initial testing was completed in 2002 by forty veteran employees in Tampa and Bay Pines, FL. Currently, there are over 800 testers and evaluators and over 200 self-registered users at four medical centers and in all VISN 2 sites who are critiquing Phase 2 and 3 pilot efforts and providing feedback to the Implementation Task Force. "Our goal," says Ginger Price, Acting VHA Project Manager for My Health*e*Vet, "is to assure that this is a good thing for both clinicians and veterans. We're seeking lots of clinical input to format implementation guidelines for Phases 2 and 3. This is going to be a change for all of us, so we want to make sure that veterans and clinicians can take full advantage of all the functionality without it becoming a burden."

"Veterans have been very positive about My Health*e*Vet," Ms. Price noted. "They like it. We can't get the functionality out fast enough for them. There's a market for it, and they'll use it when it's out there."

Current plans are to roll out Phase 3 incrementally by VISN. "We'll need lots of help from clinicians, patient educators and librarians to fully implement Phase 3," Ms. Price stated.

"For now, this project is an information technology (IT) initiative, but when it's fully implemented, the IT role should be to support, not to drive the effort. We're looking for a physician to give more direct input to the program," Ms. Price added.

Website Addresses

The web address for My Health*e*Vet is: http://www.myhealth.va.gov. To view the pilot for the electronic health record functionality, go to http://www.health-evet.va.gov, using "demouserb" as the username and "password_$1" as the password.

For further information contact:

Ginger Price, MA, Acting Director, Health Informatics Strategy, VHA Office of Information, and Acting VHA Project Manager, My Health*e*Vet, Silver Spring, MD; (301)734-0504; ginger.price@med.va.gov

Group Orientation Clinic at VAMC San Francisco

The Medical Practice Orientation Clinic was established seven years ago to educate patients about the VA health care system and to reduce the no-show rate for initial primary care visits. The clinic was created by a group of nurses with input from physicians.

A part-time nurse conducts the clinic five times a week over a 3-day period. Each session lasts from one to two hours depending on the number of participants. On average, 50-60 veterans are seen each week in this clinic. According to Ann Englert, coordinator of the clinic, most veterans are referred through the telephone care program at the medical center or through the emergency room. "I triage them and schedule them for the orientation clinic. We get 60-70 consults per week for this clinic. We're now getting lots of referrals for Philippine Scouts who've recently been authorized by Congress to receive care at VA facilities."

At each session, patients are seen individually to review vital signs and urgent health care needs, along with clinical reminder information to be entered into their medical records. They are also given refills of any current VA prescriptions that may run out before their first primary care visits. Then the patients convene as a group. Discussion centers on the information contained in the folder each patient receives:

- information about the VAMC primary care program and the variety of clinical and non-clinical services available to them and how to access them
- information about patient rights and responsibilities
- general health information
- a personal health profile to complete and bring to the first visit.

A pharmacist comes in to review VAMC protocols for obtaining and refilling medications, and to answer questions patients may have about their medications. A clerk assigns primary care appointments for patients while the group is meeting.

"Most patients are not happy that they have to attend this clinic before receiving a primary care appointment," says Ms. Englert, "but afterward they say they're surprised at how much they've learned. They really appreciate having someone to talk with who is responsive to their needs. They tell us it makes them feel that they are not just a number, and that reduces their anxiety about using the VA health care system. Their confidence in their ability to maneuver though this enormous system is greatly increased."

She also noted that physicians like the orientation clinic because they spend less time with new patients explaining the system and more time getting to know them. "Plus, their no-show rates for first appointments have dropped to about 20%, so they're happy about that," she added.

For further information contact:

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Group Orientation and Prevention Clinics at VAMC Oklahoma City

Starting last summer, Dr. Boyd Shook, Associate Chief of Staff for Ambulatory Care, developed two new clinics—an orientation clinic for all new patients, and a prevention clinic for patients interested in learning what they can do to promote their own health. Dr. Shook conducts each clinic twice a week; sessions last one hour. Educational materials are disseminated to the participants in these clinics. He developed a PowerPoint presentation for the orientation clinic that explains the VA health care system. "Patients request a copy of the presentation," he notes. "It gets rave reviews." He has also created templates for documentation of these clinic activities in patients' medical records.

"We believe that groups are very efficient in terms of physician resources because one physician can educate a number of patients at the same time," he said. "They're also very effective in getting people thinking about their questions before they see their own physicians. There's lots of interaction in these sessions. We're all learning to talk more openly about our health concerns. Patients even call me now to tell me how they're doing."

The orientation clinic focuses on primary care so that patients will be able to use the VA health care system effectively, but the larger context is comprehensive care, including how patients and their clinicians can work together as partners. "For primary care panel management it is crucial to have patient involvement in the care process," Dr. Shook said. The prevention clinic focuses on healthy behaviors that promote good health, including weight management, food habits, exercise, immunizations, health screening, quitting tobacco use, and limiting alcohol intake.

There is a plan to offer a clinic discussion once a month on a specific topic; examples include diabetes and smoking cessation. All patients in the database with that particular health problem will be invited to attend. Based on response to the preventive clinics, this will likely be another popular approach to getting patient involvement.

Plans include expanding the number of physicians who conduct the clinics and asking the primary care nurses to work with the clinics. The goal is to involve all primary care physicians and nurses in the clinics in order to share the workload and to give all physicians and nurses the opportunity to experience the positive group interaction with patients.

For further information contact:

Boyd Shook, MD, Associate Chief of Staff for Ambulatory Care and Assistant Chief, Medicine, VAMC Oklahoma City, OK; (405) 270-5122; Boyd.Shook@med.va.gov

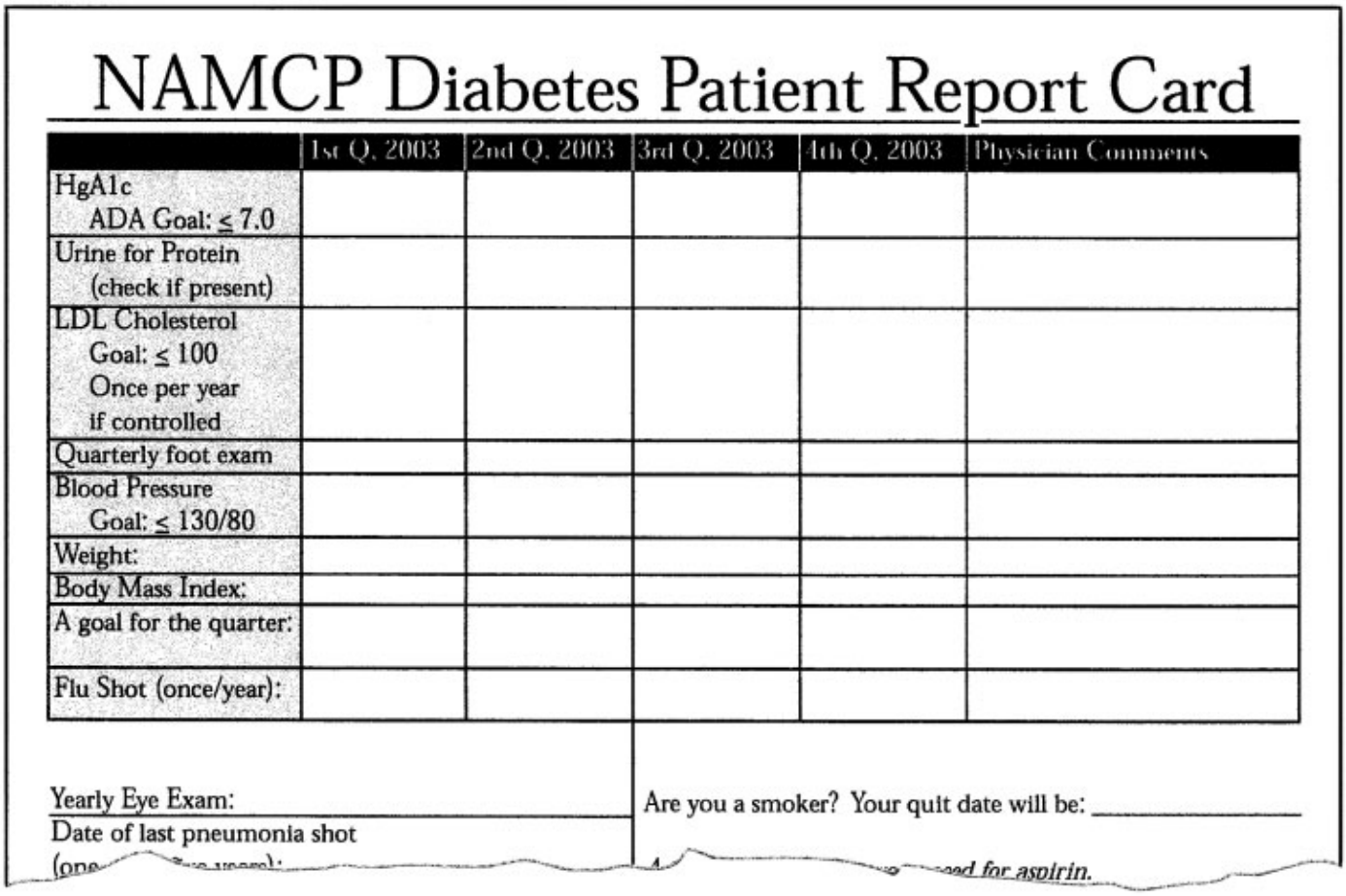
Patient Education Resources

Patient Report Cards

The National Association of Managed Care Physicians has developed a series of report cards for patients. The cards are tools that patients can use to monitor their progress toward goals set in visits with their physicians. Patients are encouraged to bring the report cards to each clinical visit.

Patient report cards are available for diabetes and asthma; additional topics are planned. The front of the card displays a chart of health status goals for that condition (based on clinical practice guidelines) with space to tailor the patient's individual goals every quarter of the year. The back of the card provides space for medication notes and physician comments for up to six visits, plus an exercise log. According to Dr. Bill Williams, Executive Vice President of the association, "the cards help patients participate actively in their care, and they help patients focus on specific three-month goals to improve or maintain their health status."

The cards are copyrighted but are available at no cost upon request to Dr. Williams at the association. He can be reached at (804) 527-1905, or by e-mail at bwilliams@namcp.org.



NAMCP Diabetes Patient Report Card

	1st Q. 2003	2nd Q. 2003	3rd Q. 2003	4th Q. 2003	Physician Comments
HgA1c ADA Goal: ≤ 7.0					
Urine for Protein (check if present)					
LDL Cholesterol Goal: ≤ 100 Once per year if controlled					
Quarterly foot exam					
Blood Pressure Goal: ≤ 130/80					
Weight:					
Body Mass Index:					
A goal for the quarter:					
Flu Shot (once/year):					

Yearly Eye Exam:

Date of last pneumonia shot

Are you a smoker? Your quit date will be: _____

Teach Tip

Helping Patients Who Are Thinking About Changing a Health Behavior

It's often hard to know how to help patients who are aware that they need to make a health behavior change, but haven't yet started to change. The hallmark of this stage of change is ambivalence—the patient is more aware of the pros of changing, but also acutely aware of the cons of changing. Patients at this stage, called the contemplation stage for behavior change, may be considering the possibility of changing but have not yet made a decision to change. It's still just an idea, not an action plan. An example is the patient who says, "I know I should quit smoking, but I really like to smoke."

It's important to remember that the goal for working with a patient who is in this stage is **not** to get the patient to change the behavior, but to help the patient evaluate the pros and cons of changing. Only when the pros outweigh the cons, will the patient be ready to move to the next stage.

Try any of the following strategies, tailoring your approach to the needs of particular patients:

- Establish a positive relationship with the patient (*I can hear that you're thinking about making this change, and I'd like to help you with that.*)
- Express empathy—assure the patient that his feelings of ambivalence and doubt are normal; they're positive steps on the path of change, not reasons to be discouraged
- Assess the patient's perceptions:
- how important it is to change (on a scale of 0-10)
- how confident he is in his ability to change (on a scale of 0-10)
- Explore things further by asking: *What made you give yourself a 6 instead of a 2? What keeps you from moving up from 6? How could you move up to an 8?*
- Help the patient examine the pros and cons of changing and not changing, either by having the patient fill out a balance sheet at home or through conversation with you during the visit. Include the following prompts in a balance sheet:
- consequences to self (both pros and cons)
- consequences to others (both pros and cons)
- reactions of self (both pros and cons)
- reactions of others (both pros and cons)
- Encourage the patient to visualize the future if he changes the behavior, and if he doesn't change the behavior
- Encourage the patient to self-monitor his current behavior to get an accurate sense of consumption or frequency of the behavior
- Encourage the patient to talk with others who are working on the same behavior
- If the patient appears concerned about the behavior, explore the concerns further to help both of you understand the situation better (*What concerns you most about the behavior? What do you believe is causing the problem?*)

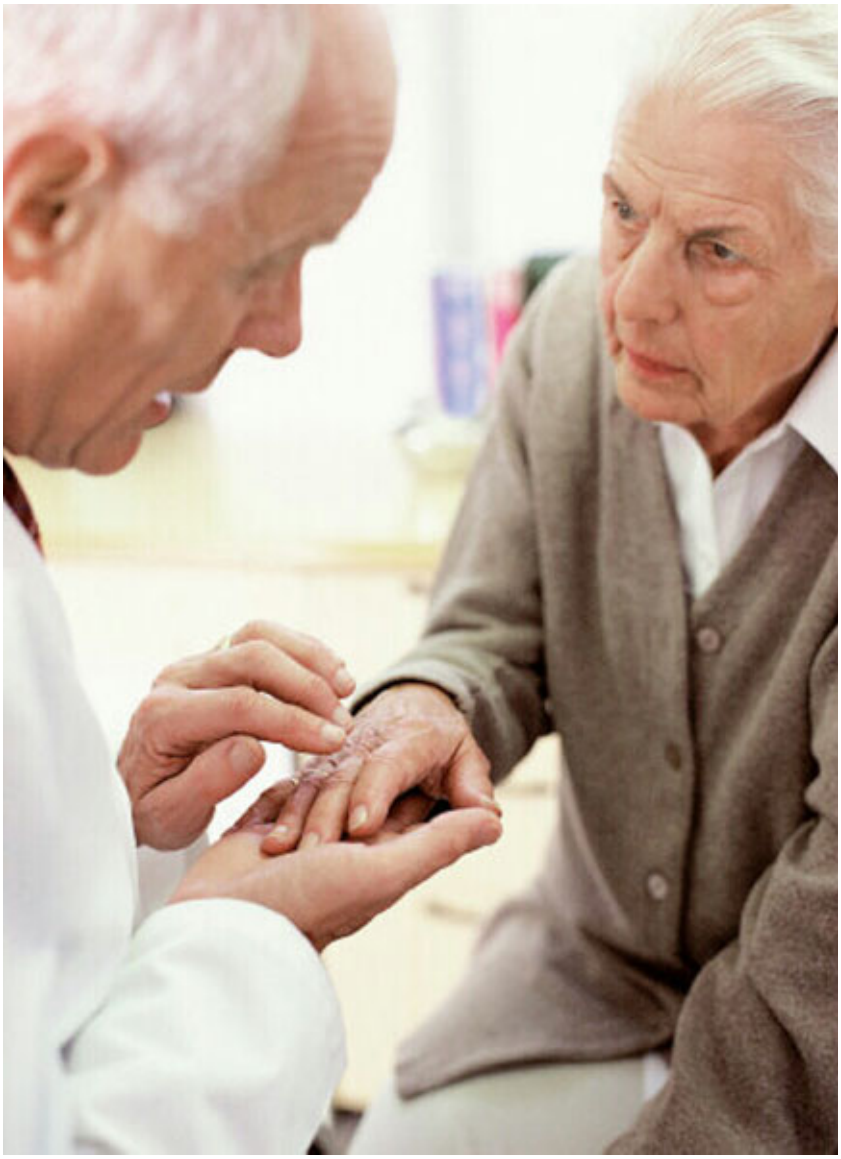
What **not** to do:

- Try to sell the pros or cons—likely to generate patient resistance and frustration for both of you
- Push for action—puts the patient off; doesn't help the patient handle his ambivalence
- Prescribe the behavior change you think the patient should make, or scare the patient—likely to fail and to create negative feelings for both of you

How do we know patient education works?

Collaborative Care Management of Late-life Depression in Primary Care Settings

This randomized controlled trial was undertaken to evaluate a collaborative care management program for late-life depression. The intervention included access for up to 12 months to a depression care manager who was supervised by a psychiatrist and a primary care expert. The depression care manager offered education, care management, and support of antidepressant management by the patient's primary care physician or a brief course of psychotherapy for depression. Participants were recruited over a 24-month period from eighteen primary care clinics of eight health care organizations in five states. The study population included 1801 patients aged 60 years or older with major depression (17%), dysthymic disorder (30%), or both (53%). Assessments for depression, depression treatments, satisfaction with care, functional impairment, and quality of life were conducted at baseline and at 3, 6, and 12 months.

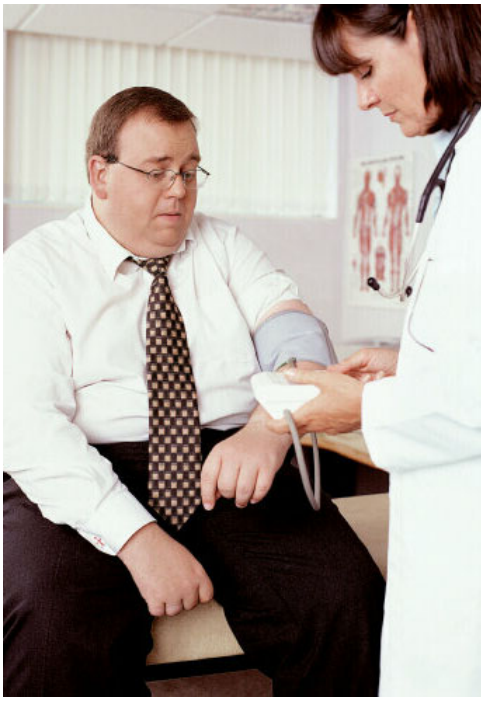


At 12 months, 45% of intervention patients had a 50% or greater reduction in depressive symptoms from baseline compared with 19% of usual care participants. Intervention patients also experienced significantly greater rates of depression treatment, more satisfaction with depression care, lower depression severity, less functional impairment, and greater quality of life than patients assigned to usual care.

The authors conclude that the collaborative care model was demonstrated to be feasible and significantly more effective than usual care for depression in a wide range of primary care practices.

Unutzer J, Katon W, Callahan CM, Williams JW Jr, et al. (2002) Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. JAMA, 288(22):2836-45.

Patient Knowledge of Hypertension



To assess patient knowledge of hypertension, the authors randomly surveyed 2500 hypertension patients from the Northern California Region of the Kaiser Permanente Medical Care Program. Questionnaires were supplemented with clinic blood pressure measurements.

72% of the patients completed the surveys. Among patients with uncontrolled hypertension (systolic blood pressure > or = 140 mm Hg and/or diastolic blood pressure > or = 90 mm Hg), only 20% labeled their blood pressure as high and 38% labeled it borderline high. Only 60% of patients could recall their most recent clinic-based blood pressure values. 72% were unable to report a target systolic blood pressure, and 61% were unable to report a target diastolic blood pressure. Most patients perceived diastolic blood pressure as a more important risk factor than systolic blood pressure.

The authors conclude that more patient education is needed for better management of hypertension.

Alexander M, Gordon NP, Davis CC, Chen RS. (2003) Patient knowledge and awareness of hypertension is suboptimal: results from a large health maintenance organization. Journal of Clinical Hypertension, 5(4):254-60.

Health Care Providers' Practices Regarding Stress and Health Outcomes

The authors administered a survey to primary care providers in the outpatient medical clinics of a southeastern urban hospital serving a predominantly African-American indigent population. The instrument was designed to assess their training, perceptions, and practices regarding stress and health outcomes.

72% of the 210 providers completed the survey. 42% reported receiving no instruction regarding stress and health outcomes during their professional education. Although 90% of respondents believed that stress management was very or somewhat effective in improving health outcomes, 45% rarely or never discussed stress management with patients.

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Respondents were twice as likely to believe that counseling patients about smoking, nutrition, or exercise was more important than counseling them about stress. 76% reported a lack of confidence in their ability to counsel patients about stress. 57% of the respondents rarely or never practiced stress reduction techniques themselves.

Data analysis indicated that belief in the importance of stress counseling and its effectiveness in improving health, and confidence in one's ability to teach relaxation techniques were related to the probability that providers would counsel patients regarding stress.

The authors contend that knowledge about stress and disease and skills in stress reduction should be incorporated into professional preparation and continuing education for health care providers.

Avey H, Matheny KB, Robbins A, Jacobson TA. (2003) Health care providers' training, perceptions, and practices regarding stress and health outcomes. Journal of the National Medical Association, 95(9):833, 836-45.

Brief Educational Interventions to Reduce Stroke Risk

This pilot study was intended to determine whether a brief educational intervention tailored to the patient's stage of readiness to change could influence risk-reducing behaviors for patients at risk for stroke. Participants included 60 patients with multiple risk factors for stroke from a family practice clinic. The majority of patients were African-American, with a mean age of 68.

Participants were randomly assigned to three groups: brief intervention tailored to stage of readiness to change; simple advice; and control. There were significant positive correlations between the action stage of readiness to change and initiation and achievement of new behaviors to reduce risk of stroke. There were also significant differences in the number of new behaviors and stroke knowledge among the three groups.

Miller ET, Spilker J. (2003) Readiness to change and brief educational interventions: successful strategies to reduce stroke risk. Journal of Neuroscience in Nursing, 35(4):215-22.

Performance Improvement Training

Every quarter, *Patient Education in Primary Care* will offer the opportunity to earn one hour of performance improvement training credit for a patient education topic of importance to primary care clinicians. To earn this credit, choose one of the following two options:

Read the entire October 2003 newsletter and provide brief answers to the questions below. Turn these in to your supervisor along with a copy of the newsletter

OR

Organize a one-hour brown bag journal club or set aside time during a staff or team meeting to read the newsletter and discuss the questions below. Turn in a master list of participants along with a copy of the newsletter.

Questions:

1. What strategies are being used at your facility to educate patients about My HealtheVet? How might these efforts be expanded? What can you do to help?

2. What kind of orientation is offered to new enrollees at your facility? What suggestions would you make to enhance this orientation?

3. To what extent do clinicians at your facility explore the topic of stress and health outcomes with patients? How might this topic be addressed with clinicians and patients at your facility?

DO YOU HAVE ANY SUCCESSFUL PATIENT EDUCATION STRATEGIES THAT YOU WOULD LIKE TO SHARE WITH US?

Contact any of the following with your input:

Barbara Hebert Snyder
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René Haas
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Charlene Stokamer
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Coming in JANUARY:

How VISNs and facilities are implementing the VA *Time is Life* heart attack education program

PATIENT HEALTH EDUCATION IN PRIMARY CARE TASK FORCE:

This newsletter is transmitted electronically to VHA staff. To add colleagues to the distribution list, contact your local patient education coordinator or committee chairperson.

Employee Education System

Office of Primary and Ambulatory Care

TELL US ABOUT THE TOPICS YOU WOULD LIKE TO SEE COVERED IN FUTURE ISSUES